LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH

CLINICAL INCIDENT (EVENT) NOTIFICATION DMH POLICY 202.18, ATTACHMENT 1 Revised 07-21-15

PLEASE PRINT OR COMPLETE THIS ADMINISTRATIVE REPORT ON A COMPUTER AND KEEP ONLY ONE COPY IN AN ADMINISTRATIVE FILE

DO NOT SAVE THIS REPORT ON A COMPUTER, E-MAIL IT, INCLUDE OR REFERENCE IT OR RELATED DISCUSSIONS WITH CLINICAL RISK MANAGEMENT IN THE CLIENT'S RECORD.

1. CLIENT LAST NAME	2. CLIENT FIRST NAME	3. BIRTH DATE	4. AGE	5. SEX	6. IS#	7. EVENT DATE	8. SERVICE AREA

9. PROVIDER:#	10. MHSA OR OTHER SPECIAL PROGRAM:	11. CONTRACT PROVIDER NAME/ADDRESS	12. EVENT LOCATION	13. M.D. / D.O./ N.P./ P..A.

14. DIAGNOSES	15. LIST THE FREQUENCY AND DOSAGES OF ALL CURRENT MEDICATIONS

THE RESPONSE TO ITEM 16. BELOW IS TO DETERMINE IF THE MEDICATION REGIMEN IN ITEM 15 . ABOVE IS WITHIN DMH PARAMETERS FOR THE PRESCRIBING OF PYCHOACTIVE MEDICATIONS, WHICH CAN BE ACCESSED AT HTTP://DMH.LACOUNTY.GOV/TOOLSFORCLINICIANS/CLINICAL_PRACTICE.HTML

THE RESPONSE MUST BE DETERMINED BY THE PRESCRIBER/ FURNISHER /SUPERVISING M.D., OR MANAGER/DESIGNEE.

NOTE: AN "N" RESPONSE REQUIRES THE COMPLETION OF ITEM 23. ON PAGE 2.

16. IS THE REGIMEN IN ITEM 15. ABOVE WITHIN DMH PARAMETERS? ☐ Y ☐ N. IF N, CHECK APPLICABLE BOXES A-D BELOW.

☐ A. USE OF TWO OR MORE ANTIPSYCHOTICS	☐ B. USE OF TWO OR MORE NEW GENERATION ANTIDEPRESSANTS	☐ C. USE OF A BENZODIAZEPINE IN A CLIENT WITH A CO- OCCURRING SUBSTANCE USE DISORDER.	☐ D. OTHER: PLEASE SPECIFY:

17. CLINICAL INCIDENT TYPE: (CHECK): *ASTERISKED NUMBERS REQUIRE SUBMISSION OF **PG. 2 WITHIN 30 DAYS** OF THE REPORT

- ☐ 1. DEATH-OTHER THAN SUSPECTED/ KNOWN MEDICAL CAUSE
- ☐ 2. DEATH- SUSPECTED/KNOWN MEDICAL CAUSE
- ☐ *3. DEATH- SUSPECTED SUICIDE (ALSO COMPLETE ITEM 24.)
- ☐ *4 SUICIDE ATTEMPT REQUIRING EMERGENCY TREATMENT (EMT) (ALSO COMPLETE ITEM 24.)
- ☐ *5. CLIENT INJURED SELF (NOT SUICIDE ATTEMPT) OR WAS INJURED BY ANOTHER CLIENT REQUIRING EMT
- ☐ *6. CLIENT INJURED ANOTHER REQUIRING EMT
- ☐ *7. HOMICIDE BY CLIENT
- ☐ *8. MEDICATION ERROR/ MEDICATION EVENT
- ☐ *9. ALLEGED CLIENT ABUSE B STAFF
- ☐ *10. POSSIBILITY OR THREAT OF LEGAL ACTION

18. DESCRIPTION OF THE INCIDENT: INCLUDE IMPORTANT FACTS. IF NEEDED, USE AN ADDITIONAL SHEET(S) THAT INCLUDES A STATEMENT OF CONFIDENTIALITY (THE LAST SENTENCE AT THE BOTTOM OF THIS PAGE.) ATTACH OTHER INFO, E.G. NEWSPAPER ARTICLES.

19. REPORTING STAFF: (PRINT/TYPE)	MANAGER'S NAME/REPORT DATE	21. MANAGER'S SIGNATURE	22. MANAGER'S PHONE #

THIS SECTION IS FOR INTERNAL USE ONLY

SEND PG. 1 TO RODERICK **SHANER,** MD, LAC DMH MEDICAL **DIRECTOR**, 550 S. VERMONT AVE., 12TH FL., LOS ANGELES, CA 90020 WITHIN 1 BUSINESS DAY FOR DIRECTLY-OPERATED PROGRAMS AND 2 BUSINESS DAYS FOR CONTRACT AGENCIES. SEND THE MANAGER'S REPORT OF CLINICAL REVIEW (PG. 2) WITHIN 30 DAYS TO THE CLINICAL RISK MANAGER FOR ASTERISKED (*) CATEGORIES 3-10 ABOVE AND FOR A "N" RESPONSE TO ITEM 16. CONTACT MARY ANN O'DONNELL, RN, MN CLINICAL RISK MANAGER FOR QUESTIONS. PH: 213-637-4588.

Note: If the event in Section 17 on pg. 1 is a Type 3 or 4 event, do not submit this page 2. Use the Manager's Report of Clinical Review for Types 3 and 4 events in the Clinical Risk Management section of the Clinical Practice Page on the DMH Internet.

Revised 07-21-15

LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
CLINICAL INCIDENT (EVENT) NOTIFICATION MANAGERIAL REVIEW

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SEND THIS PAGE WITHIN 30 DAYS OF THE CLINICAL INCIDENT AFTER COMPLETING A CLINICAL REVIEW FOR INCIDENTS IN ASTERISKED CATEGORIES 3-10 ON PG. 1, OR IF THERE'S AN "N" RESPONSE TO ITEM 16 ON PG. 1, TO: MARY ANN O'DONNELL, R.N., M.N. CLINICAL RISK MANAGER, LAC-DMH, 550 S. VERMONT AVE., 12TH FL. LOS ANGELES, CA 90020. PH.: 213-637-4588.

CLIENT LAST NAME:	CLIENT FIRST NAME	IS #	MGR'S NAME: (PRINT)	MGR'S SIGNATURE	DATE SUBMITTED

23. IF ITEM 16. ON PG. 1 IS "N," DOES THE CLINICAL RECORD CONTAIN:
A. THE RISKS/BENEFITS FOR THE USE OF THE MEDICATION(S)? ☐Y ☐N AND, IF APPLICABLE,
B. DOCUMENTATION OF A CONSULTATION WITH THE FURNISHING SUPERVISOR IF THE MEDICATIONS WERE FURNISHED BY AN N.P. OR P.A.? ☐Y ☐N NOTE: IF EITHER A. OR B. ARE "N", PLEASE COMPLETE C. AND D. BELOW.

C. THE MANAGER, SUPERVISING M.D. OR FURNISHING SUPERVISOR HAS INFORMED THE M.D. /D.O./N.P./P.A. OF THE REQUIRED DOCUMENTATION AS STATED IN THE DMH GUIDELINES FOR THE USE OF THE PARAMETERS, ITEM #. 5. ☐Y ☐N

D. THE M.D./D.O./N.P./P.A./ HAS ACKNOWLEDGED THE REQUIREMENT AND HAS AGREED TO COMPLY WITH THE REQUIREMENT IN THE FUTURE. ☐Y ☐N

24. WAS THE INCIDENT IN ITEM 17. ON PG. 1 A CATEGORY 3. SUSPECTED SUICIDE OR CATEGORY 4. A SUICIDE ATTEMPT REQUIRING EMERGENCY MEDICAL TREATMENT? ☐Y ☐ N IF "Y," ENTER:
A. DATE OF LAST SERVICE PROVIDED:
B. TYPE OF LAST SERVICE PROVIDED:
C. LIST DATE(S) AND **NATURE** OF KNOWN PRIOR ATTEMPT(S) REQUIRING EMERGENCY MEDICAL TREATMENT AND ANY FAMILY HISTORY OF SUICIDE:

D. WAS THE CLIENT DISCHARGED FROM AN INPATIENT FACILITY WITHIN THE LAST 30 DAYS? ☐Y ☐ N IF "Y", ENTER FACILITYNAME:_____DISCHARGE DATE: _____ DATE OF IST FACE TO FACE APPT POST DISCHARGE:_____
E. OTHER RELEVANT INFORMATION, E.G., RECENT STRESSORS:

F. WAS THERE DOCUMENTATION OF A DISCUSSION WITH THE CLIENT FOR ACTIONS TO TAKE WHEN FEELING SUICIDAL? ☐Y ☐ N IF "N," PLEASE EXPLAIN.

25. IF SUBSTANCES WERE A FACTOR IN ITEM 16, WAS THE CLIENT RECEIVING CO- OCCURRING SUBSTANCE ABUSE TREATMENT? ☐Y ☐ N IF N, PLEASE EXPLAIN.

26. WAS A POST-INCIDENT TEAM CASE REVIEW DONE? ☐Y ☐ N IF "Y" , ATTACH CASE REVIEW FINDINGS MARKED "THIS INFORMATION IS PRIVILEGED AND CONFIDENTIAL UNDER EVIDENCE CODE SECTION 1197 AND GOV'T CODE 6254 [C.]"

27. LIST ANY PRE-DISPOSING FACTOR(S) OR ROOT CAUSE(S) RELEVANT TO THIS OCCURRENCE:

28. LIST ANY SYSTEMS, E.G. PARAMETERS, POLICIES & PROCEDURES OR TRAININGS IN YOUR AGENCY OR THROUGH DMH THAT YOU HAVE IDENTIFIED AND/OR INSTITUTED IN ORDER TO PREVENT SIMILAR EVENTS IN THE FUTURE: